The extent to which cultural and religious disparities in Cognitive Behavioural Therapy (CBT) might impact effectiveness of treatment and the mental-health wellbeing of Muslims with South-Asian family heritage living in the UK

Ahmed Khan
University of Huddersfield

Abstract

Overview: Muslims of South-Asian family heritage living in the UK, have varying, yet typically significant, cultural and religious differences compared to the indigenous population. The context and extent of behaviour and life experiences drawn from familial heritage alongside the degree of British lifestyle assimilated, can manifest a complicated ecosystem. The mental-health wellbeing of this sizeable and continually growing element of the UK population, falls to be considered in relation to the efficacy of available treatments. Given South-Asian Muslims are amongst the most economically disadvantaged, recourse to NHS solutions are often inevitable. One of those treatments, CBT, whether that be of low or full intensity, is regarded as the gold standard offered through the NHS England IAPT programme. Moreover, CBT is more widely available than any other talking-therapy from fee-generating independent accredited therapists. Cultural and religious awareness training together with recommended CBT adaptations for those serving BAME groups in general is evident and promoted. However, CBT efficacy for South-Asian Muslims, whilst advocating techniques to encourage positive change in negative thinking, mood, and behaviours, must inevitably require an understanding of diverse endemic cultural nuances and an eclectic mix of fervent Islamic beliefs. This may require contextually profound appreciation of core individual drivers, requiring an arsenal of lived-experiential cognitions for which there is no suggested panacea. Some tender that CBT is acultural and areligious; however, such a conceptual approach may be too superficial, undermining and overlooking the essence and drivers of individual cognitive distortion. Such a stance may ultimately inhibit treatment efficacy and the potential for sustained mental-health wellbeing.

Methods and Analysis: A comprehensive literature review will be undertaken through a thematic synthesis of the literature, to evaluate CBT and interactions with South-Asian Muslims. This will include focus on evidence of: therapeutic outcomes; effectiveness of therapist cultural and religion-based adaptation and integration; client relapse frequency; the basis for remission longevity. Qualitative fieldwork: using grounded theory to examine patterns arising form analysis of the primary data; and, remission rates alongside subsequent levels of sustained mental-health wellbeing amongst South-Asian Muslims resulting from CBT therapy. Development of a proposed diagnostic framework for the target group using participatory action research and focus groups to effectively identify and inform CBT therapeutic methods.

Ethics and Dissemination: The study will accord with the British Psychological Society Code of Ethics and Conduct, being subject to approval by the presiding ethics committee of the Department of Psychology, University of Huddersfield. Given this research is expected to produce novel outcomes, the research and appropriate anonymised data corpus would accordingly be tendered for publication.

Keywords: Mental-health wellbeing, CBT, Muslims, South-Asian family heritage
Background & Overview

People of South-Asian family heritage are the largest Black and Minority Ethnic (BAME) group in the UK accounting for 7.5% of the population, of which circa 5% are affiliated to Islamic faiths. Unlike other BAME groups, the number of Muslims within the population is growing substantially, increasing by 56% between the 2001 and 2011 censuses.

Moreover, they are said to be amongst the most economically disadvantaged, a factor which may restrict access to, and choice of, more widely-available private mental-health services (Equality & Human Rights Commission, 2018; Citizens UK, 2017).

Over the last 60-years, Muslims of South-Asian family heritage (MUSAH) have become well-established in the UK, and are essentially of Indian, Pakistani, and Bangladeshi origins (Office for National Statistics, 2013). Indeed, this group has emerged from a shared context of historic, political, (pre-partition) geographical, cultural, and religious commonalities, being profoundly influenced by Islamic core doctrines.

Research conducted in the UK has suggested MUSAH may present with mental-health conditions that manifest in different ways, such as through somatic symptoms. These are considered not readily identified within mental-health treatment frameworks, particularly concerning Pakistani women (Khan, Lovell, Lunat, Masood, Shah, Tomenson, & Husain, 2019).

A Mind report in 2013 suggested that both healthcare providers and professional therapists considered they in fact addressed cultural and religion-based diversity within their therapy sessions, 87% and 75% respectively. However, only 10% of BAME community focus-group participants expressed that talking-therapies had appropriately interfaced with their cultural and religious needs (Mind, 2013).

This is an especially important consideration given the majority (83%) of primary healthcare IAPT personnel, and thus the key point of contact for most MUSAH clients with mental-health needs, are white British (NHS England, 2016).

Cognitive Behavioural Therapy (CBT) as a treatment, to address such mental-health needs, has become by far the most acclaimed and effective evidence-based talking-therapy for treating mental-health conditions in the UK, if not worldwide (Carlson & González-Prendes, 2016; Tyrer, 2013; Tolin, 2010).

CBT is recognised as a gold-standard psychological therapy and recommended by the National Institute for Health and Care Excellence (NICE) across NHS England (NHS, 2018).

The NHS route to accessing CBT therapies for those with mental-health wellbeing needs is through the primary care ‘Improving Access to Psychological Therapies’ (IAPT) programme. Alternatively, a plethora of accredited and registered CBT therapists can be accessed and remunerated privately.

Over the last two decades, articles and guidelines recommending either cultural or religious adaptations to CBT and similar mental-health therapies, concerning BAME clients, have been increasingly evident and cited (e.g. Arday, 2018; Tummala-Narra, Sathamivam-Rueckert, & Sundaram, 2013; Minnis, Kelly, Bradby, Ogletorpe, Raine, & Cockburn, 2003; Tabassum, Macaskill, & Ahmad, 2000).

Indeed, this September (2019), the British Association for Behavioural and Cognitive Psychotherapies (BABCP), the UK & Ireland CBT Lead Body, also updated their corresponding IAPT BAME guidance.

This guidance not only highlights BAME-recommended marketing and interaction methods, but also advocates the integration of cultural and religion-based contexts by adapting therapy. The latter includes shared engagement techniques, such as jointly exploring client genograms during initial stages of, and to inform, therapy.

The guidance, however, suggests polarisation in clinical provision through standardisation or systematic compatibility matching of BAME clients to therapists, is generally not appropriate (BABCP, 2019).

Articles and guidance typically advise that being able to assimilate cultural nuances in professional CBT settings may require training in the use of specially adapted cultural and religious methods and interventions. This is recommended, however, irrespective of any client and therapist cultural and religious common ground or contextual understanding. Edge and Lemetyinen (2019), assert that deficits in culturally shared experiences between such parties can be a negative influence that might misconstrue diagnosis.

Undoubtedly, culture and religious awareness training (e.g: diversity, racism, inequality, unconscious-bias, et al.) is widely-subscribed, being proactively encouraged by lead bodies and healthcare authorities amongst IAPT providers and CBT professionals alike (Naz, Gregory, & Bahu, 2019).

Such training aims to raise awareness of specific cultural and religious prejudices and related implicitly-held associations concerning perception, interaction with, and management of, BAME clients. However, the literature shows that such cultural and religion-based training is often brief, being typically of one/two days’ duration. Attendee learning is said to be susceptible to ineffective consolidation post-training nor well-managed through relevant supervised continuous professional development or organisational integration.

Moreover, experiences derived from cultural and religion-based awareness training is suggested to have the opposite of the intended effect. This includes inducing and
reinforcing negative contextual stereotypes, prejudice, racism, and unconscious bias, which is inherently counterproductive (Shepherd, 2019; Geering [Producer, BBC Radio 4], 2019; Noon, 2018; Dobbin & Kalev, 2017).

Ensuring cultural and religion-based guidance and training is consistently embedded with providers, personnel, and organisationally is, therefore, inevitably challenging. Moreover, therapist reticence to engage BAME clients directly concerning potentially controversial cultural and religious aspects, is suggested as also arising from perceived professional risk and liability (Rosmarin, Green, Pirutinsky, & McKay, 2013).

According to Tan (2013), evidence of both cultural and religion-based therapy adaptation integration, and related positive BAME client experience, is untested. Indeed, any evidence of thorough research, including such as randomised control trials, concerning the efficacy of adapted CBT, including those specifically for MUSAH, does initially appear mediocre and limited in the literature; albeit some limited specific research (including within related MUSAH countries) is summarily evident (e.g. Aslam, Irfan, and Naeem, 2015; Farooq, Gul, Irfan, Munshi, Asif, Rashid, Khan, Ghani, Malik, Aslam, Farooq, Husain, & Ayub, 2015; Rathod, Phiri, Harris, Underwood, Thagadur, Padmanabi, & Kingdon 2012).

A paucity of quality research may be attributed to wide cultural and religion-based diversity and scope for interpretation amongst MUSAH populations per se. Combinations of random implicit importance and centrality to individual psychology of cultural and religious adherence, is, therefore, potentially vast. Consequently, any standardised application of CBT cultural or religion-based adaptation or process, given substantial heterogeneity amongst BAME client groups, is at risk of being mutually exclusive.

Hussain and Hodge (2016) assert that effective CBT interventions and long-term mental-health remission amongst MUSAH will necessarily depend on the detailed cultural and religious experiential knowledge of therapists at least, or associated cultural and religious compatibility between the parties at best.

Moreover, cultural and religious aspects are considered misaligned with the typical evidence-base of what is deemed a largely Westernised CBT application. Subsequently, MUSAH response to such therapy is suggested as tenuous where cultural and religious integration is poorly applied or absent (Carlson et al., 2016; Anand & Cochrane, 2005).

Well-being management both during and post-therapy also relies heavily on the ability of the client to comprehend and utilise various CBT tools and techniques imparted during guided therapy. Client application of such methods may fail where therapeutic interpretations are divergent, and this can serve to magnify symptoms and stimulate aggregations of mental-health vulnerabilities (Vervliet, Craske, & Hermans, 2013; Hardeveld, Spijker, De Graaf, Nolen, & Beekman, 2010; Burcus & Iacono, 2007).

Predominantly, therefore, this research study aims to identify the influence of remission and longevity of mental-health wellbeing amongst MUSAH within the UK, based on their prior experience of, and reflections on, CBT. The research will also seek to elicit the experiences of CBT professionals regards MUSAH clients, to include: i) therapy management; ii) cultural and religious contextual integration during therapy sessions; iii) sustainable outcomes and relapse rates.

Proposed Research Objectives

1. Understand and identify the extent to which cultural and religion-based differences between therapists and MUSAH clients impact upon therapeutic mechanisms and outcomes
2. Examine what therapeutic processes are felt to be important amongst MUSAH clients for maintaining positive mental-health wellbeing and how they believe these should be adapted
3. Explore potential for anonymised online conferencing platforms to enable discussions about mental-health wellbeing issues that are stigmatised within the UK MUSAH population

References


Culturally adapted CBT (CaCBT) for depression: A randomized controlled trial from Pakistan. *Journal of Affective Disorders*, 177, 101-107. doi: 10.1016/j.jad.2015.02.012


Efficacy of CBT and UK Muslims with South-Asian family heritage

Psychology: Research and Practice, 44(1), 1-10. doi:10.1037/a0027809
